Evaluation and Treatment of Opioid Use Disorders in Remote Areas with Telemedicine

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Disclosure Information (Required)

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  - Presenter 1 “No Disclosures
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  - Presenter 2 “No Disclosures”
  - Drs. Roe and Dekker are federal employees but do not represent any federal or tribal organization. Their opinions for this educational program are solely their personal opinions.

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Learning Objectives

- There is clear data indicating a rise in opioid overdose deaths during the COVID epidemic. Some of this is secondary to a decrease in available support services (AA, NA, Group therapy and F2F individual therapy) Also availability of MAT has wide geographic variation. Veteran and ADSM dependents have had challenges in MAT availability. Telemedicine has become the norm for provision of services. The Indian Health Service, BOP and other federal providers have witnessed a rise in COVID restrictions and OUD care has been challenged.
- **At the conclusion of this activity, the participant will be able to:**
- 1: To recognize clinical challenges in COVID related settings for diagnosis and treatment of Opioid Use Disorders (OUD) in remote settings.
- 2: To implement Medications used for Addiction Treatment (MAT) via telemedicine with the new rules of engagement enacted during the COVID pandemic.
- 3: To discuss the clinical challenges that COVID has brought to patients burdened with Opioid Use Disorders and the clinical staff providing services.

35 Year Old Native Veteran

- IED blast with surgical intervention, chronic pain after failed back surgery. Difficulty getting Opioid management in mid 2020 and started oral fentanyl in Fall 2020. Naloxone rescue in NOV 2020 and placed on buprenorphine. No WIFI available for 12 miles from home.
- Goes to the McDonald's Parking lot in Tuba City for WIFI.
- Can we continue buprenorphine 8/2 SL BID?
- Other options?

New COVID-19 related VHA/OAA flexibilities for Graduate Medicine Education (GME) trainees

- VHA/OAA Veterans Health Administration/Office of Academic Affiliations
- Allow non-collocated tele-supervision.
- Allow funding for medical students to start their residencies before June 22, 2020.
- Allow GME residency trainees to “moonlight” as trainees and be paid for extra work.
- Allow expedited credentialing of GME fellowship trainees to permit “moonlighting” as attending physicians in area of primary (but not secondary specialty).

Title 38 U.S.C. Section 7302

New COVID-19 related VHA/OAA flexibilities for GME trainees

- Use of “weather & safety” leave for residents in quarantine.
- Allow shortened telework training and privileges to work from home (with appropriate non-collocated supervision).
- Allow GME residency trainees to receive pay for being on a reserve pool.
- Allow distance learning options, and extra time in some cases to allow completion of clinical experience or research.

Title 38 U.S.C. Section 7302

Federal Addiction Medicine Focus

- Alcohol Use Disorders
- Screening methodology (AUDIT-C => Alcohol Use Disorder Identification Test – Consumption
- Opioids and OUD Risk
- Substance Abuse Disorder
- Behavioral Health Issues and Suicide Prevention
- Treatment Criteria – Latest Updates
- Prevention of Spread of COVID-19 and mutations

Stephenson J. Drug Overdose Deaths Head Toward Record Number in 2020, CDC Warns. *JAMA Health Forum*. Published online October 20, 2020. doi:10.1001/jamahealthforum.2020.1318

Additional Focus

- Prevention of Suicide and Overdoses with Opioids
- Clinical Institute Withdrawal Assessment for Alcohol Scale- revised (CIWA-Ar)
- Withdrawal Management Protocol Examples
- FDA Approved and non-approved treatment of alcohol use disorders
- Opioids and long-term OUD management
- Methadone and Buprenorphine
- Clinical Opioid Withdrawal Scale (COWS)
- Non-Pharmaologic Treatments

Stephenson J. Drug Overdose Deaths Head Toward Record Number in 2020, CDC Warns. *JAMA Health Forum.* Published online October 20, 2020. doi:10.1001/jamahealthforum.2020.1318

Ryan Haight Act
(Online Pharmacy Consumer Protection Act of 2008)

- Provider may prescribe controlled substances if he/she as conducted at least one in-person exam or meets the “practice of telemedicine” exception and the COVID-19 exception
- Exceptions
  - VA Provider or Active Duty and Civilian Military providers (maybe)
  - Indian Health Service or Tribal Health Provider (maybe)
  - In an emergency medical situation
  - Situations approved by the Attorney General & Secretary of Health & Human Services consistent with 2020 changes

https://www.deadiversion.usdoj.gov/fed_regs/rules/2020/fr0930_2.htm

Section 3232 of Substance Use Disorder Prevention that Promotes Opioid Recover and Treatment (SUPPORT) for Patients and Communities Act of 2018

- Promotes increase in use of telemedicine to combat opioid crisis.
- American Telemedicine Association proposed loosening of exceptions to include:
  - Updating DEA regulations to have distinctions between traditional and telemedicine prescribing privileges. Expanded 2020 in light of COVID
  - Allow both sites and prescribers to register for telemedicine.
  - Allow telemedicine prescribers to have DEA registration in multiple states.
  - State and hospital variations exist and you must be aware of the laws

https://www.congress.gov/bill/115th-congress/house-bill/6

VA MISSION ACT 2018

- Named for John McCain, Daniel Akaka, and Samuel Johnson- became PL 115-182 on 6/6/18. **VA M**aintaining **I**nternal **S**ystems and **S**trengthening **I**ntegrated **O**utside **N**etworks

- Primary purpose: Establish a permanent community care program for Veterans , to establish a commission for the purpose of making recommendations regarding the modernization or realignment of facilities of the Veterans Health Administration (VHA)…..
- Allows non VA providers to register and provide services and receive reimbursement for veteran care.
- Increases ability of VA licensed independent practitioners to use telemedicine across state lines (but not trainees).

https://www.congress.gov/bill/115th-congress/senate-bill/2372

Subtitle B- Improving Department of Veterans Affairs Health Care Delivery

SEC 151: LICENSURE OF HEALTH CARE PROFESSIONALS OF THE DEPARTMENT OF VETERANS AFFAIRS PROVIDING TREATMENT VIA TELEMEDICINE.

(a) IN GENERAL- Chapter 17 is amended by inserting after section 1730B as added by section 134, the following section:

§1730C. Licensure of health care professionals providing treatment via telemedicine

(a) IN GENERAL- Notwithstanding any provision of law regarding the licensure of health care professionals, a covered health care professional may practice the health care profession of the health care professional at any location in any State, regardless of where the covered health care professional or the patient is located, if the covered health care professional is using telemedicine to provide treatment to an individual under this chapter.

https://www.congress.gov/bill/115th-congress/senate-bill/2372

VA Telemed Options

- Traditional Telemedicine Visits – Patient is scheduled for an appointment at a site with a telehealth coordinator/tech and with a provider at a different VA site.
- VA Video Connect (VVC) – Physician schedules a visit with the patient(s) in the near or more distant future. They can be conducted from smartphones or computers into a virtual exam room that may include multiple patients or guests.

VA Video Connect (VVC)

- Get consent from the patient for the visit.
- Find out who else is in earshot of the call.
- Get the full address of the Veteran's location and telephone number for back up
- Get the name of another person (when possible) and another phone number for contact just in case the call drops, battery dies, signal is lost, crisis, etc…
- Have the telephone number of first responders for that specific location
- Two identifiers, informed consent, patient initiation, start and end times and proper documentation.
- Some have Bluetooth equipment connections

Telemedicine VS Telesupervision

- Currently Tele-supervision is not permitted by the ACGME or by VA for GME residents other than in emergency care situations.
- Some associated health specialties (e.g. psychology, clinical pastoral training) allow some tele-supervision.
- VA OAA differentiates between patient centered supervision (must be on site) and trainee centered supervision (may be off site).
- OAA and accrediting bodies have relaxed tele-supervision rules to allow the supervisor to be apart from the trainee as long as they are in the visit together with the patient.

Did We Get Here

- Institute for Healthcare Improvement- Don Berwick, Minimize or eliminate Pain in Healthcare
- Joint Commission, Policy and Procedures for Pain Evaluation and Care
- Pain and the 5th Vital Sign
- Increase in opioid prescribing by 400%
- Perdue Pharma and other manufacturers and Distributors
- Provider Education
- PDMP CSPMP
- BOMEX and licensing boards

Associations between stopping opioids to overdoses and suicides

- British Medical Journal, January 2020
- Oliva et al , VA Menlo Park CA and Yale University with several authors
- 1,394,102 veterans with an outpatient prescription from FY 2012-2013
- 799,668 stopped opioid prescriptions (57.4%)
- 2887 deaths from overdose or suicide
- Stratified by length of treatment, less than 30 days, 31-90 days, 91 to 400 days and greater than 401 days

Length of Opioid Treatment

- 30 days or less, 32%
- 31- 90 days 8.7%
- 91 to 400 days 22.7%
- Greater than 401 days 36.6%

Death Hazard Ratios for those who stopped opioids

- 30 days or less, 1.67
- 31- 90 days 2.8
- 91 to 400 days 3.95
- Greater than 401 days, 6.77

Hazard risks for suicide

- 30 days or less, 2.02
- 31- 90 days , 3.43
- 91 to 400 days, 4.78
- Greater than 401 days, 7.99

Overdose VS Suicide

- 1851 Overdose
- 1249 Suicide
- 13 excluded because of missing data
- Increase risk with opioids greater than tramadol, increased morphine mg equivalants (MME), number of medical diagnoses, mental health or substance use disorder, younger, male and being single.

CASE 2 – 52 Yr old female

- Chronic EtOH use with recent exacerbation
- Chronic pain syndrome from pancreatitis acute on chronic
- Prescribed tramadol perceived as inadequate by patient
- Street sourced opioids, oxycodone, hydrocodone morphine taken orally for uncontrolled abdominal and back pain, MME > 120
- Intermittent homelessness and COVID infection allowed her to enroll in the hotel program

Alcohol Use Disorder (AUD) in Veterans

- 42% of Veterans screen positive at some point during their lives for an AUD[1] (screening is a risk assessment- does not imply presence of disease.)
- Veterans with Alcohol Use Disorder[2]
  - Die an average of 15 years earlier
  - >2x higher risk for death (non-injury)
  - >3x higher risk of death (by injury)

1 Fuehrlein, B., et. al. Burden of AUD in US Military Veterans: National Health and Resilience in Veterans Study. *Addiction*. May 2016
2 Fudalej S. et al. Predictors of injury-related and non-injury related mortality among veterans with alcohol use disorders. *Addiction*. July 2010

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Screening for AUD

- For Alcohol consider the AUDIT- C (Alcohol Use Disorder Identification Test-Consumption)
  - How often do you have a drink containing alcohol? (0-4 – a score of 4 is 4 or more times a week)
  - How many standard drinks containing alcohol do you have on a typical day? (0-4)
  - How often do you have 6 or more drinks on one occasion? (0-4)

AUDIT C

- Commonly used, validated in Veteran populations
- Maximum score of 12 pts- ≥ 3 in women and ≥ 4 in men indicate risk of AUD
- Validated in studies that include Veteran population.
- Sensitivity men 86%, women 73%
- Specificity men 89%, women 91%

Alcohol Clin Exp Res. 2007 Jul;31(7):1208-17. Epub 2007 Apr 19

Substance Use Disorder?

- ✓ *Tolerance
- ✓ *Withdrawal
- ✓ **Use in larger amounts or duration than intended**
- ✓ **Persistent desire to cut down**
- ✓ Giving up other interests to use substances
- ✓ **Great deal of time spent obtaining, using,** or recovering from alcohol or **opioids or other drugs**
- ✓ Craving or strong desire to use alcohol or opioids or other drugs
- ✓ Recurrent use resulting in failure to fulfill major role obligations
- ✓ **Recurrent use in hazardous situations**
- ✓ Continued use despite social or interpersonal problems caused or exacerbated by alcohol or opioids
- ✓ **Continued use despite physical or psychological problems**

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision

Mild SUD: 2-3 Criteria
Moderate SUD: 4-5 Criteria
Severe SUD: ≥6 Criteria

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.)

2020 ASAM Alcohol Withdrawal CIWA-Ar

- High scores are predictive of development of seizures and delirium. Good tool to determine care setting.
  - < 9-10 = mild symptoms
  - 10-18 = moderate symptoms
  - ≥ 19 = severe symptoms-high risk
- Scale is currently being used for medication administration at many detoxification centers.
- Using the CIWA-Ar symptom triggered protocol was found to reduce side effects from over-sedation costs by avoiding unnecessary use of medications.

Sullivan JT, Sykora K, Schneiderman J, Naranjo CA, Sellers EM. Assessment of alcohol withdrawal: the revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar) Br J Addict. 1989;84(11):1353–7.

SAMPLE ALCOHOL WITHDRAWAL Rx

- Diazepam, Chlordiazepoxide, and Lorazepam most frequently used. Front loaded, fixed dose, and symptom triggered protocols all work well.
- Carbamazepine- 200mg QID on days 1-3, then 200mg TID day 4, then BID day 5 , then QD day 6.
- Valproate 300mg QID x 3 days, then taper by 300mg/day.
- Gabapentin- 300mg-600mg QID on days 1-3 then 300mg-600mg TID on day 4, 300mg -600mg BID on day 5 and 300mg-600mg HS on day 6.

Wong J, Saver B, Scanlan JM, et al. The ASAM clinical practice guideline on alcohol withdrawal management. *J Addict Med.* 2020;14(3S Suppl 1):1-72. doi: 10.1097/ADM.0000000000000668

FDA Approved Options for AUD

- Disulfiram

  Inhibits aldehyde dehydrogenase- cause nausea, vomiting, flushing, headache with alcohol intake.

  Black box warning- safety issues

- Naltrexone - oral and injectable
  - Reduces reward from alcohol by blocking opioid receptors- box warning removed.
- Acamprosate
  - Thought to inhibit action of glutamate on NMDA receptor and interact with GABA system

Non-FDA Approved AUD Options

- Gabapentin – effects on GABA A and glutamate
- Topiramate- Antagonizes glutamate receptors, modulates cortico-mesolimbic dopamine release and enhances GABA.
- Tricyclic antidepressants (co-morbid depression)
- SSRIs
- Complementary and Alternative Medicine (CAM)- Vitamin/herbal infusions, biofeedback, acupuncture, animal therapy, yoga. Lack high quality evidence at this time.

Opioids

- Low long-term success rates for detox are poor without medication ~10% remain abstinent after 2 years. Still use motivational approach.
- If detox is considered, it should be pharmaceutically assisted and combined with some form of rehab.
- After detox is complete, consideration should be given to long term naltrexone therapy (380mg monthly injectable demonstrates better results than oral due to compliance). Some pharmacies are willing to provide injection therapies.
- What is the most expensive treatment? The one not taken and the one that did not work. Hopelessness is a consequence of loss of recovery.

American Society of Addiction Medicine, *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use* (2015)

25 Yr old male

- Hx of heroin and methamphetamine use, starting fentanyl use
- Recent psychiatric hospitalization for suicidal ideations
- Injectable buprenorphine (Sublocade) use but often misses scheduled injection
- High levels of anxiety and loss of trust with COVID limitations on F2F visits
- Feels betrayed by treatment team because of access difficulties and insecurity of treatment process.

Telemed BH and SUD Essentials

- If possible, start with an in person visit and get consent for telemedicine future contacts. Discuss accessibility issues.
- Be aware of your personal items in the background, and look professional (they can do a screenshot), noise control, two phones
- Need two identifiers, location address, informed consent for telemedicine care, telephone back up numbers, start time and end time. Some insurers require the patient initiate the contact.
- With each contact repeat consent, have a telephone number to call if there is an emergency. Where is the exact location of the patient? Who else is present? Is the patient safe? Who is supportive of the patient and their contact and consent to discuss care /contact? Release of information.
- Some states allow one party to record conversations and contacts without the other party's knowledge or consent. Assume recordings may occur.
- Initial interview includes current situation, current treatment, medications, safety and triggers and loss of recovery prevention, and safety plan

Rubin, JAMA Vol 322, Number 11, Sep 2019

Telemed BH & SUD

- Have the local Public Safety numbers for where the patient is.
- Know the bandwidth for contact 1G and 3G are not adequate, G4 and G5 eat data, adequate WIFI is great
- Therapeutically at the beginning of each session establish and maintain the therapeutic relationship.
- Monitor voice pressure, eye contact, body movements and posture, ask for basic setting (home, restaurant parking lot)
- Have a treatment plan and goals for each contact.
- Document how is the patient maintaining care and or recovery and document a safety plan

Telemed BH & SUD Issues

- Comorbidity Issues, Depression, ASPD, legal issues, child care, occupational issues
- Current emotional status, Columbia SSRS
- Recovery support, AA, NA, Smart Recovery, etc
- Spirituality and Traditional Customs Issues
- Other health issues: infections, Hep C, HIV, STI, COVID-19
- Group therapy agreement, boundaries, rules of engagement
- How do you monitor (UDS, etc)?
- Ryan Haight Act
- Medications for Addiction Treatment Issues, Informed consent and regularity of contacts

Long Term OUD Management

- Buprenorphine and Methadone are considered first line treatments for opioid use disorder. Long term success rates are much higher than with detox, between 60%-80% remain in treatment after one year.
- Make sure the patient understands the risks and benefits of therapy. Informed consent.
- Make sure the parameters of prescribing are clearly understood by the patient before beginning. – consider a treatment contract.
- Record an appropriate history and document a physical exam.

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Fiellin DA, Pantalon MV, Chawarski MC, et al. Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence. N Engl J Med. 2006;355(4):365-374.

OUD with Buprenorphine

- Comply with state and federal laws.
- Currently (April 2021) the XDEA waiver is still required. Even if the DEA waiver is no longer required for an XDEA in the future– find a mentor! www.pcssnow.org

  ****training will still be available****
- Refer to an established OTP clinic for methadone treatment or for buprenorphine if appropriate structure is not available in your practice setting. (Especially for high risk, pregnant, young, Med Complexity
- Buprenorphine is approved for DATA2000 care as sublingual, buccal and subdermal injections.

Buprenorphine

- Mu partial agonist, kappa & delta antagonist- less issues with sedation and respiratory depression
- Approved in sublingual, buccal, and subdermal forms with or without naloxone for treatment of opioid addiction
- Has good pain relieving properties at low/intermediate doses (8mg-16mg/day)- but possible ceiling effect at high doses (>24mg/day)
- May not be as successful in blocking the mu receptor reward from fentanyl.
- Viable option for patients with addiction and pain who are willing to participate in the addiction treatment program.
- Should be started when patient is in moderate withdrawal to prevent “precipitated withdrawal”

Clinical Opioid Withdrawal Scale (COWS)

- 11 items including:
  - Resting pulse
  - Pupil size
  - GI upset
  - Anxiety or Irritability
  - Sweating
  - Bone/Joint aches
  - Tremor
  - Gooseflesh
  - Restlessness
  - Rhinorrhea/tearing
  - Yawning
- Score:
  - 5-12 = Mild Withdrawal
  - 13-24 = Moderate
  - 25-36 = Moderately Severe
  - >36 = Severe Withdrawal

Non-pharmacologic Treatments OUD

- 12 Step meetings (support not treatment), AA/NA/ Celebrate Recovery
- SMART recovery, LifeRing, Moderation Management, Women for Sobriety, Secular Organizations for Sobriety, other secular groups
- Insight oriented "process" groups
- Cognitive or Dialectic Behavioral Therapy
- Motivational Enhancement
- Coping Skill Enhancement
- No group has a significantly better outcome than the others- given the same length of treatment.

Safety Measures for Chronic Opioid Rx

- Give controlled substance use agreement
- Check morphine equivalents (doses > 100 are high risk, over 180 are very high risk for overdose. (CDC guideline uses 50/90)*
- Avoid concomitant benzo use when possible.
- Check Prescription Drug Monitoring Program (PDMP).
- Check urine toxicology
- Check depression screen
- Give Naloxone prescription

COVID, OUD and Stress

- Complications from OUD have risen dramatically.
- Fentanyl and its congeners have had severe negative impacts
- Recognize that these are stressful and unusual circumstances and risk for fatigue may be increased.
- Create a culture of safety with clear coordination and communication between management and workers. This can include establishing a Fatigue Risk Management Plan or strategies for fatigue mitigation on the job. Share and ensure that employees understand the processes.

Taking Care

- Help staff feel well-trained, physically, and mentally fit, motivated, calm, steady and in control prior to the crises
- Empower staff to care for each other
- Listen
- Watch
- Avoid emphasis on negative issues
- Build in time to recover from negative events

Final Takeaways/Summary

- Increase patient adaption of telemedicine with commercial acquired equipment using minimal attachments;
- Maximize physical examination attachments like dermatological, cardiovascular, GI and pulmonary assessments;
- Understand federal and state regulations regarding controlled substances;
- Implement individual and group psychotherapy provided by and to multiple sites and settings; and
- Enhance understanding of information around buprenorphine inductions and maintenance via telemedicine. Participants will leave this session with a new appreciation for how comprehensive psycho-therapeutic evaluation and care can be achievable with high grade telemedicine equipment and providers.

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- Polling questions (35 yr old male veteran fentanyl, 52 yr old female OUD and EtOH, 25 yr old male OUD and methamphetamine)
- Which cases met the criteria of OUD severe?
- Which cases were appropriate to be on buprenorphine?
- What other treatments should be considered for each?
- Would you provide care to each via telemedicine?
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